Journal of Contemporary Health Law & Policy (1985-2015)

Volume 14 | Issue 2 Article 9

1998

Compulsory Caesarean Sections: An English Perspective

Robert Fancis

COMPULSORY CAESAREAN SECTIONS: AN ENGLISH PERSPECTIVE

*Robert Francis QC**

I. INTRODUCTION

Few medical procedures have given rise to such anxiety and debate as delivery by Caesarean section. It has become something of a battle ground between feminists, or "pro-choice" opinion, and those claiming to defend the rights of the unborn child. In physical terms, the clash between the two points of view could not be more acute, as in many cases it is quite impossible to accommodate both the wishes of the mother to preserve her body from what she perceives as a violation and the survival of her viable fetus.

Against such a background, it is not surprising that the courts of common law jurisdictions have been confronted with urgent and difficult cases resulting in decisions which raise as many questions as they answer and which are heavily criticised by advocates of competing schools of thought. Such cases may provide illustrations of the advantages of a common law system in adapting old methodologies to new problems and the disadvantages inherent in judicial legislation in the absence of legislative guidance from elected representatives of society.

The purpose of this Article is not to suggest answers in a field where it is impossible to satisfy all, but to provide an account of the experience of courts of England and Wales. It seeks to describe the principles that were developed in medical decision making before the spate of cases concerning Caesarean sections; give an account of those cases and their judgments; summarise the resulting state of English law; and, finally, to consider whether society has been well served by this process.

---

* Robert Francis graduated in law from Exeter University in 1971 and was called to the Bar of England and Wales in 1973. He was appointed Queen's Counsel in 1992. He specialises in medical ethical and malpractice law. He has appeared in some of the cases cited in this Article. This Article retains British spelling and citation form.

II. Authority for Medical Treatment

A. Adults

English law adheres to the fundamental legal principle that a person's body is inviolate unless he consents to, or there is some other legal authority for, the invasion. In general, any form of medical treatment without the patient's consent is unlawful and renders the doctor so acting liable to prosecution or civil action for assault or trespass to the person. In England, unlike some other common law jurisdictions, the consent required may be based on an understanding of the general nature of the proposed treatment, rather than detailed knowledge of the attendant risks. Failure to give accurate information of the risks of the procedure does not invalidate the consent given, even if it may render the doctor liable for breaching his duty of care by failing to give appropriate warnings.[1]

The possibility of an exception, central to the cases to be considered in this Article, was adumbrated in *Re T*[2] where Lord Donaldson of Lymington MR said:

> An adult patient who, like Miss T., suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment, to refuse it or to choose one rather than another of the treatments being offered. The only possible qualification is a case in which the choice may lead to the death of a viable fetus. That is not this case and, if and when it arises, the courts will be faced with a novel problem of considerable legal and ethical complexity.[3]

It should be noted that no suggestion was offered as to a legal basis for such an exception. There are well-recognised exceptions to the requirement for the patient's consent, apart from certain types of treatment for mental disorder that may be authorised under mental health legislation.

B. Children

Consent to medical treatment performed on a child may be provided by a person having parental responsibility.[4] The courts have statutory

1. *Sidaway v. Board of Governors of Royal Bethlem & Maudsley Hospitals* [1985] AC 871 (HL).

2. *Re T. (Adult: Refusal of Treatment)* [1993] Fam 95, 102.

3. *Id.*

4. For this purpose, a child is any person under the age of 18. Consent may also be given by a child of any age for him or herself if in possession of a sufficient degree of maturity and understanding. Consent by any party that has the power to do so permits

and inherent powers to make orders authorising medical treatment.[5] Such decisions must be made in the best interests of the child.

C. Mentally Incompetent Patients

English law is strangely deficient in providing a means for making decisions in cases of adult patients who are mentally incapable of doing so for themselves or even if otherwise competent, unable to communicate their decision. Until recently, the position with regard to the treatment of the mentally incompetent was uncertain. Obviously such treatment was given, but without any intervention by lawyers and probably without much thought to its legal basis. Thus, Skegg, writing in 1984, was able to state: "although it is generally accepted that a doctor is sometimes justified in proceeding without consent, there is no English case which is directly on point."[6]

The most helpful line of authority available at the time was from the Canadian courts,[7] the effect of which was that if treatment was necessary for the protection of life or the preservation of health, a doctor was justified in providing treatment, without consent, to adult patients incapable of consenting for themselves.[8]

The problem was not addressed by the English courts until *T v. T*[9] and then more fully and authoritatively by the House of Lords in *Re F.*[10] It was discovered that the inherent protective power over incompetent adults, granted to the courts by virtue of the royal prerogative, had been withdrawn, possibly under the misapprehension that the matter was now covered by mental health legislation. Therefore, the court could not authorise medical treatment in the sense of making lawful that which would otherwise be unlawful. Furthermore, no relative or other third party had the power to provide a proxy consent. The House of Lords was obliged to search for a principle by which treatment and care of the in-

---

treatment to be given, even if another party disagrees. *Gillick v. West Norfolk & Wisbech Area Health Authority* [1986] 1 AC 112, 169-70; *Re R (A Minor)(Wardship: Consent to Treatment)* [1993] 3 WLR 592.

5. For example, under Children Act 1989 section 100(3) as in *Re T (A Minor)(Wardship: Medical Treatment)* [1997] 1 WLR 242; *Re W (A Minor)(Medical Treatment Court's Jurisdiction)* [1992] 3 WLR 758.

6. PDG SKEGG, LAW, ETHICS AND MEDICINE 101 (1984).

7. *Marshall v. Curry* [1933] 3 DLR 260; *Winn v. Alexander* [1940] 3 DLR 778; *Murray v. McMurchy* [1949] 2 DLR 442; *Johnston v. Wellesley Hospital* [1970] 17 DLR (3d) 139; *Schweizer v. Central Hospital* [1974] 53 DLR (3d) 494.

8. *Id.*

9. [1988] Fam 52.

10. *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL).

competent could be legitimated and such a principle was identified in the doctrine of necessity. Thus, it was held that where a person is mentally incompetent or unable to communicate a decision as to treatment, and will not recover such capacity within time for treatment to restore or prevent a deterioration in health, it is lawful for such treatment to be provided in the best interests of the patient. Such interests are to be determined in accordance with responsible and competent medical practice, and following the test laid down in *Bolam v. Friern Hospital Management Committee*.[11] In other words, if in such a case a doctor decides that treatment is in the patient's best interests, he may lawfully provide such treatment if he acts competently, and no consent of any third party or the court is required.

It was recognised, however, that there were cases, such as the sterilisation of mental patients, where it would be prudent for some form of additional safeguard to be provided. In the absence of a wardship jurisdiction or its equivalent, the best that could be devised was the use of the court's jurisdiction to make declarations. A declaration does not render lawful that which would otherwise be unlawful, but does provide a mechanism whereby the court can inquire into whether the decision to treat has been competent and responsible. There is, however, an inherent limitation in a procedure that applies the *Bolam*[12] test in this way: where there is more than one responsible and competent school of thought, it may be lawful to provide treatment and equally lawful not to do so. The court cannot then easily choose between the competing opinions.

III. Patient and Fetal Rights in Obstetrics

An obstetrician continually faces the dilemma caused by a perception of an ethical duty to both the mother and her fetus as separate entities. The Royal College of Obstetricians' guidelines state that:

> The aim of those who care for pregnant women must be to foster the greatest benefit to both the mother or fetus, and inform and advise the family, utilising their training and experience in the best interests of parties. Obstetricians must recognise the

11. [1957] 1 WLR 582. This case laid down the principle that:

> [A] doctor who had acted in accordance with a practice accepted at the time as proper by a responsible body of medical opinion skilled in the particular form of treatment in question was not guilty of negligence merely because there was a body of competent professional opinion which might adopt a different technique.

Id.

12. *Id.*

> dual claims of the mother and her embryo or fetus and inform and advise the family, utilising their training and experience in the best interests of both parties.[13]

The legal position in England and Wales has, in general, not recognised this dual obligation. On several occasions, the courts have refused to recognise the fetus as having any legal personality giving the court jurisdiction to intervene. Thus, in *Paton v. British Pregnancy Advice Service*,[14] a husband was not permitted to apply for an injunction to restrain the abortion of a fetus of which he was the father. Sir George Baker P was clear that the fetus had no rights:

> The first question is whether this plaintiff has a right at all. The fetus cannot, in English law, in my view, have a right of its own at least until it is born and has a separate existence from its mother. That permeates the whole of the civil law of this country (I except the criminal law, which is now irrelevant), and is, indeed, the basis of the decisions in those countries where law is founded on the common law . . . there can be no doubt, in my view, that in England and Wales the fetus has no right of action, no right at all, until birth.[15]

In *C v. S*,[16] it was held that an unborn child had no *locus standi* to prevent an abortion. Heilbron J said:

> The authorities, it seems to me, show that a child, after it has been born, and only then, in certain circumstances, based on he or she having a legal right, may be a party to an action brought with regard to such matters as the right to take, on a will or intestacy, or for damages for injuries suffered before birth. In other words, the claim crystallises upon the birth, at which date, but not before, the child attains the status of a legal persona, and thereupon can then exercise that legal right.[17]

In *Re F*,[18] the court held that it lacked jurisdiction to make an unborn child a ward of court even to protect it from damage likely to be caused by its mother. This is not to say that acts and omissions during birth may not have consequences after birth. Thus, the common law recognises that an action in negligence may be brought by a child once born alive for

13. *A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Intervention* paras. 4.3.1.-4.3.2. (Royal College of Obstetricians & Gynaecologists, 1996).

14. [1979] QB 276.

15. *Id.* at 279.

16. [1988] QB 135.

17. *Id.* at 140 (citing Canadian authorities, *Medhurst v. Medhurst* [1984] 46 OR (2d) 263; *Deliler v. Ottawa Civic Hospital* [1979] 25 OR (2d) 748; [1980] 29 OR (2d) 677).

18. *Re F (In Utero)* [1988] Fam 122.

injuries inflicted as a result of antenatal acts or omissions.[19] A charge of homicide will lie against a person for an assault on a pregnant woman resulting in the death of the child, if initially born alive. *Attorney General's Reference No 3*[20] stated:

> Murder or manslaughter can be committed where unlawful injury is deliberately inflicted either to a child *in utero* or to a mother carrying a child *in utero* in the circumstances postulated in the question. The requisite intent to be proved in the case of murder is an intention to kill or cause really serious bodily injury to the mother, the fetus before birth being viewed as an integral part of the mother. Such intention is appropriately modified in the case of manslaughter . . . . The fact that the death of the child is caused solely in consequence of injury to the mother rather than as a consequence of injury to the fetus does not negative any liability for murder and manslaughter provided that the jury are satisfied that causation is proved.

A similarly ambivalent view is taken by the English legislature. On the one hand, the Abortion Act 1967 authorises terminations of pregnancy in a wide range of cases. On the other, the Infant Life (Preservation) Act 1929 prohibits the destruction of any child capable of being born alive.[21] The Congenital Disabilities (Civil Liability) Act 1976 clarifies the common law position in relation to liability to the child born alive for injuries *in utero*.

With respect to the mother, the general common law position is clear: a competent adult patient cannot be forced to submit to medical treatment, however well-intentioned, and however necessary to preserve life or health.[22] *Re F*[23] established that treatment could be given to a patient incapable of consenting to treatment if it was in the patient's best interest. How this would be applied in obstetric management was unclear. As will be seen, the perceived imperative to save life, fetal and maternal, resulted in what may be considered surprising developments in the definition of mental capacity and of patients' best interests.

---

19. *Burton v. Islington Health Authority* [1993] QB 204 CA.

20. [1996] 2 WLR 412.

21. This is subject to an exception under the Abortion Act 1967 in relation to a fetus of 24 weeks or more that is likely to be seriously handicapped at birth. ABORTION ACT 1967 section 1 (as amended by the HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990).

22. *Sidaway v. Board of Governors of Royal Bethlem & Maudsley Hospitals* [1985] AC 871 (HL).

23. *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL).

IV. Compulsory Obstetrics

Until 1988, no case appears to have been brought before the English courts in which an attempt was made to authorise the imposition of obstetric management on a woman without lawful consent. The extension of the declaratory jurisdiction[24] by the cases of *T v. T*[25] and *Re F*[26] to include issues of mental capacity and best interests of the patient with a practical requirement for "sensitive" cases to be referred to court, inevitably set the scene for obstetric cases to be the subject of applications.

A. The Caesarean Section Cases

While they have provoked considerable controversy, there have in fact been very few cases in which courts in the United Kingdom have been asked to consider a proposal to deliver a baby by Caesarean section against the will of the mother. It might be presumed that before the advent of the declaratory jurisdiction referred to above, doctors did not consider it necessary to seek such a safeguard, relying on some form of medical paternalism to justify their actions. In the case of competent patients, it is more likely that it did not occur to doctors to perform such procedures if their persuasive powers failed to convince the patient of the need for it. In any event, as will be seen from the cases that have come before the courts, such problems usually arise in circumstances of great urgency and it may not have been thought practicable to involve the machinery of justice in addressing the issues. It may be possible that the ever-increasing threat of litigation arising out of obstetric accidents has been a powerful motivating force behind the modest flow of cases in this area.

B. The Mentally Competent Adult Patient: In re S (Adult: Refusal of Treatment)

In re S[27] was the first case brought before the courts to obtain a decla-

24. This extension has been described as "one of the most remarkable developments of modern British administrative law." Zamir and Woolf, The Declaratory Judgment 8 (Sweet & Maxwell, 2nd ed. 1993).

25. [1988] Fam 52.

26. [1990] 2 AC 1 (HL). *See* the judgments of Lord Brandon at pp. 56-57, 62-65; Lord Griffiths at pp. 70-71; Lord Goff at pp. 79-80, 83. The practise is now followed in sterilisation cases (*see Practice Note (Sterilisation: Minors and Mental Health Patients)* [1993] 3 All ER 222) and for the withdrawal of life-sustaining nutrition and hydration (*see Airedale NHS Trust v. Bland* [1993] AC 789; *Practice Note (Official Solicitor: Vegetative State)* [1996] NLJ 1585).

27. [1993] Fam 123.

ration that it would be lawful to perform a Caesarean section delivery on a woman in labour. The circumstances in which the case was brought were extraordinary and unlikely to produce reasoned jurisprudence. A thirty-year-old woman was in labour with her third pregnancy, being six days overdue with the fetus in a transverse lie and a fetal elbow projecting through the cervix. For deeply held religious reasons, the mother refused to consent to delivery by Caesarean section, although she had been advised and understood that without such a procedure she and the baby were in mortal danger. An application was made to the court by the hospital for a declaration that nonconsensual surgical delivery would be lawful. The mother was not represented, but the court was assisted by an *amicus curiae*. The judge, Sir Stephen Brown, President of the Family Division, has described what occurred in a lecture:

> During the luncheon adjournment . . . . my clerk came to me and said 'I think there is an application which somebody wishes to make about a caesarean section operation. I don't know anything about it.' It was 1:20pm or just after by the time I got in touch with [the Official Solicitor[28]] and by 2:10pm he had briefed counsel, a QC, in court. I had nothing except the form of summons, which had been issued by the health authority . . . seeking a declaration that it would be lawful for the doctors to carry out a caesarean section operation on a 30 year old woman who was in the last stages of labour with her third pregnancy. The consultant gynecologist gave oral evidence before me . . . this lady had a genuine religious objection to a caesarean section being carried out; this was a desperate situation, the fetus was lying in a position where it was nearly emerging, and if there was no intervention—and there was no doubt about it—the mother would die and also the child . . . . The question was, should that be allowed? . . . . It was very clear—this was minutes, not hours—both would die. I heard very helpful submissions by counsel for the Official Solicitor and I made the . . . declaration, telling the consultant 'please go to my clerk's room and use the telephone:' it was as vital as that.[29]

According to the report of the case, the judgment was delivered at 2:18 pm The judge noted that there was no English authority on the point,

28. The Official Solicitor is an officer of the court amongst whose duties is to assist the court as *amicus curiae* or on occasions to represent parties unable to represent themselves, such as children or mental patients.

29. *Matters of Life and Death* (Lecture to the Medico-Legal Society, Oct. 14, 1993) 62 MED. LEG. J. 52 (1994).

although it had been said that it might be possible to override the will of a competent woman to save a viable fetus.[30] However, he considered there was American authority suggesting that in a case like this the American courts would be likely to favour the grant of a declaration. He then granted a declaration according to the following terms:

> It is declared that the operation of caesarean section and necessary consequential treatment which the Plaintiff, by its servants or agents proposes to perform on the Defendant at [hospital] is in the vital interests of the Defendant and the unborn child she is carrying and can lawfully be performed despite the Defendant's refusal to give her consent.[31]

The aftermath of the case was described by an obstetrician who had been on duty in the labour ward:

> Well, of course there was chaos. I think that it was understood that the wording [of the declaration] was to save the life of the mother and the baby . . . but what happened was that the baby died during the court hearing . . . they got the phone call saying 'Its been agreed,' which was completely startling, because everyone was saying, 'There is no law on which you can bet,' and the woman was wheeled down the corridor, [w]ith the husband saying, 'What's happening?,' and they said 'Oh, we've got the agreement of the court,' and they said 'Well, what about human rights?,' and they said 'Oh, don't know about that.' They were completely dazed . . . they are African and not aware of the system, not aware of their rights, unrepresented in the court when the decision was made . . . . If this hadn't happened, the baby would have died and we would have renegotiated with the woman: 'Now, look, the baby has died and it's not going to come out. Can we now do a caesarean section?,' and she would still have refused; and she would have died without [the] court order, I am sure of that.[32]

The same doctor described the subsequent reaction to these events of the participants:

> A long time later people who were working in the hospital had not recovered from the incident, the staff, let alone the lady in question . . . the mother felt that God was acting through the agency of the gynecologist, and that is how she has forgiven him for this incident, and how she has ended up explaining it. That is

30. *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 102.

31. The text is taken from the official transcript, as it does not appear in the report.

32. *Matters of Life and Death*, *supra* note 30, at 65.

> how she has interpreted it now and that is why no appeal has come through. As far as the obstetricians are concerned, I think we are deeply divided about this. Having understood that our duty is to the baby through the mother, we don't quite like this idea of maternal/fetal conflict, because the vast majority of our work is done with the mothers and through the mothers, and the idea we can breach confidentiality and then go to make applications to divide mothers and children legally, when we can't divide them physically, is actually an anathema to many.

Faced with only minutes to decide an unprecedented case, the judge's reaction was wholly understandable: he acted to save the lives of the mother and baby. Yet, partly for the reasons expressed by the doctor quoted above, the case had many unsatisfactory features. The case found it lawful for doctors to override the clearly expressed will of a mentally competent woman and to perform invasive surgery. While time did not permit a reasoned judgment, it is clear that the justification cannot have been any perceived irrationality of the decision: there was and remains binding House of Lords authority holding that a competent adult has an absolute right to choose whether or not to undergo medical treatment: "If the doctor making a balanced judgment advises the patient to submit to the operation, the patient is entitled to reject that advice for reasons which are rational or irrational—or for no reason."[33]

The President relied on the American case of *In re AC*[34] as authority for the proposition that the American courts would have granted a declaration in similar circumstances. Unfortunately, a study of this case suggests the precise opposite. A trial court judge had granted an order, after an urgent hearing at the hospital, authorising a Caesarean section on a woman terminally ill with cancer in an attempt to save her baby. This was despite such a procedure being against her apparent wishes and the fact that the operation might shorten her life. The motions division of the District of Columbia Court of Appeals refused a stay. After the operation, the baby survived only a few hours, and the mother died two days later. The Court of Appeals then ordered the case to be heard *en banc*. On this occasion, it vacated the order of the trial judge on the ground that the substituted judgment procedure should have been followed. The court strongly suggested that the will of a mentally competent woman should never be overridden. The court, *en banc*, held that it would have

33. *Sidaway v. Board of Governors of Royal Bethlem & Maudsley Hospitals* [1985] AC 871 (HL) at p. 666 *per* Lord Templeman.

34. 573 A.2d 1235 (D.C. 1990).

been improper to presume that a patient was incompetent.[35] It supported two further arguments against overriding the patient's objections: first, it destroys the necessary trust between patient and doctor, and might drive high-risk mothers out of the health care system; and second, in this type of case, the urgency renders justice almost impossible to achieve[36] (for reasons that applied even more cogently in *Re S* itself):

> [A]ny judicial proceeding in a case such as this will ordinarily take place—like the one before us here—under time constraints so pressing that it is difficult or impossible for the mother to communicate adequately with counsel, or for counsel to organize an effective factual and legal presentation in defense of her liberty and privacy interests and bodily integrity. Any intrusion implicating such basic values ought not to be lightly undertaken when the mother is not only precluded from conducting pre-trial discovery . . . but also is in no position to prepare meaningfully for trial. As one commentator has noted "The procedural shortcomings rampant in these cases are not mere technical deficiencies. They undermine the authority of the decisions themselves, posing serious questions as to whether judges can, in the absence of genuine notice, adequate representation, explicit standards of proof, and right of appeal, realistically frame principled and useful legal responses to the dilemmas with which they are being confronted."[37]

In a passage cited by Sir Stephen Brown P, the court stated:

> We emphasize, nevertheless, that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a Caesarean section. Throughout this opinion we have stressed that the patient's wishes, once ascertained, must be followed 'in virtually all cases'. . . unless there are 'truly extraordinary or compelling reasons to override them'. . . . *Indeed some may doubt that there could ever be a situation extraordinary or compelling enough to justify a massive intrusion into a person's body, such as a Caesarean section against that person's will.* Whether such a situation may someday present itself is a question we need not strive to answer here.[38]

Therefore, the decision was hardly a ringing endorsement of compulsory Caesarean sections. However, it is only right to point out that the court

35. *Id.* at 1247.
36. *Id.*
37. *Id.* at 1248.
38. *Id.* at 1252 (emphasis supplied).

in *In re AC* expressly declined to overrule an earlier decision in the same jurisdiction, *In re Madyun*,[39] in which a trial court judge authorised a Caesarean section on the ground that the State's interest in protecting a viable fetus, which could be delivered safely, overrode the mother's rights to make a choice in accordance with her religious beliefs.[40] Further, it might be said that in *In re Madyun* there was no "real" conflict between mother and fetus in that delivery was necessary to save both lives, whereas in *In re AC* the operation was actually detrimental to the mother's prospects of survival. Nonetheless, such reasoning did not dissuade the court from the strong expression of principle cited above.[41]

Re S was the subject of considerable academic[42] and feminist[43] criticism. A competent adult's refusal of invasive surgery had been overridden partly in the interests of her fetus (until it died), and partly in her own interests. What was required in those interests was determined by others. This momentous step was taken without any representation on her behalf, and with only the most rudimentary evidence. Insofar as the decision was taken to protect the interests of the fetus, it would seem to have conflicted with the powerful *obiter dictum* of Balcombe LJ in *Re F*:[44]

> If the law is to be extended in this manner, so as to impose control over the mother of an unborn child, where such control may be necessary for the benefit of that child, then under our system of parliamentary democracy it is for Parliament to decide whether such controls can be imposed and, if so, subject to what limitations or conditions . . . . If Parliament were to think it appropriate that a pregnant woman should be subject to controls for the benefit of her unborn child, then doubtless it will stipulate the circumstances in which such controls may be applied and the safeguards appropriate for the mother's protection. In such a sensitive field, affecting as it does the liberty of the individual, it is not for the judiciary to extend the law.[45]

---

39. *Id.* at 1259.

40. *Id.*

41. The family of AC sued for malpractice in a suit settled on terms that included a statement endorsed by the AMA and ACOG, including the following: "[a] judicial proceeding is the least desirable manner to obtain authorization for treatment and should be utilized only in the absence of other surrogates . . . . Judicial authorization to override a patient's competent decision is virtually never justified." Barbara Hewson, *Mother Knows Best*, 142 NEW LAW JOURNAL 1538, 1545 (1992).

42. *See* commentary by Ian Kennedy & Andrew Grubb, *Treatment Without Consent*, 1 MED. L. REV. 92 (1993).

43. *See* Hewson, *supra* note 42, at 1538.

44. *Re F (In Utero) (Wardship)* [1988] 2 All ER 193.

45. *Id.* at 200-01.

Following this case, the Royal College of Obstetricians issued guidelines[46] that concluded by suggesting a practice of respecting the competent mother's wishes in these circumstances:

> A doctor must respect the competent pregnant woman's right to choose or refuse any particular recommended course of action whilst optimising care for both mother and fetus to the best of his or her ability. A doctor would not then be culpable if these endeavours were unsuccessful. We conclude that it is inappropriate, and unlikely to be helpful or necessary, to invoke judicial intervention to overrule an informed and competent woman's refusal of proposed medical treatment, even though her refusal might place her life and that of her fetus at risk.[47]

It was considered that resort to law to overturn the presumption in favour of patient autonomy created more problems than it solved.[48]

V. The Mentally Ill Patient: *Tameside & Glossop Acute Services NHS Trust v. CH*[49]

After an interval of over three years, the Family Division was called upon in circumstances of slightly less urgency to consider the case of a female paranoid schizophrenic who was compulsorily detained in a mental hospital under section three of the Mental Health Act 1980.[50] This is not the place for a detailed examination of a domestic mental health statute, but it should be noted that detention under it does not carry any necessary implication that the patient has lost the mental capacity to consent to or refuse medical treatment.[51] The patient wanted to have her baby and care for it, but suffered from a delusional belief that the doctors caring for her were evil and wished to harm the baby. She had a history of resisting treatment. The treating doctors became concerned at intra-uterine growth retardation and concluded that delivery by Caesarean section was necessary to safeguard the baby. They feared that the patient, whom they considered incapable of understanding the advice she received, would resist. They sought a declaration that it would be lawful to provide such treatment and to use reasonable restraint to the extent necessary for that purpose.

---

46. *A Consideration of the Law and Ethics in Relation to Court-Authorised Obstetric Intervention, supra* note 14, at paras. 4.3.1.-4.3.2.

47. *Id.* at paras. 5.11-5.12.

48. *Id.* at para. 4.5.8.

49. [1996] FLR 762.

50. *Id.*

51. *See B v. Croydon Health Authority* [1994] 22 BMLR 13.

An *inter partes* hearing took place with the patient represented by counsel, instructed by the Official Solicitor acting as *guardian ad litem* for the patient. Oral evidence was heard from the responsible psychiatrist and obstetrician. It was common ground that the evidence proved the patient to be mentally incompetent in accordance with the test formulated for medical cases in *Re C*[52] in which Thorpe J defined the necessary ingredients of competence for this purpose to be (1) the ability to comprehend and retain treatment information; (2) the ability to believe that information; and (3) the ability to weigh the information in the balance and arrive at a choice.

The judge was prepared to declare that it was lawful at common law to provide the appropriate treatment to this incompetent patient because it was in her best interests. However, he hesitated to do that because of an uncertainty about whether the common law permitted the use of restraint for this purpose, given that the legislature had made detailed provisions for the detention of mental patients and for the protection of civil liberty in this context. He therefore considered whether the legislation permitted such treatment to be given without the patient's consent. He concluded that section sixty-three of the Mental Health Act 1983[53] permitted a Caesarean section to be imposed on the patient without her consent on the grounds that it was treatment for the mental disorder from which she was suffering. The evidence before him showed that without surgical delivery the fetus would die, but the mother would suffer no physical harm. However, the birth of a stillborn baby would have had a profound deleterious effect on her mental health and would have impeded her recovery.

This interpretation of the statute is controversial,[54] but there would seem to be a pragmatic argument in favour of it in this type of case. Based upon the evidence, the mother wished to protect her baby, but by reason of her serious mental disorder, believed that the very act which would save it was intended to do it harm. If such a patient cannot be

52. [1994] 1 WLR 290, 295.

53. "The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering. . . if the treatment is given by or under the direction of the responsible medical officer." It had previously been established that this section could justify the force-feeding of an anorexic patient or one suffering from a self-harming personality disorder as being treatment for the disorder. *B v. Croydon Health Authority* [1995] Fam 133.

54. Andrew Grubb, 4 MED. L. REV. 194-198 (1996) (arguing that it is "incredible"). Barbara Hewson wrote, "A cynic's response might be: women (at any rate whilst pregnant or in labour) are a species of inferior being, who are not the same as, and are therefore not entitled to claim the same fundamental rights as men." Barbara Hewson, *Woman's Rights and Legal Wrongs*, 146 NEW LAW JOURNAL 1385 (1996).

protected from such serious consequences of her illness, it might have been thought that the mental health legislation was deficient. In any event, subsequent cases confirmed that the procedure and restraint to facilitate it would have been lawful at common law on the facts of *Re C.*

VI. An Attack of the Competence of Pregnant Women?

A. Determining the Patient's Best Interests

On June 21, 1996, two cases were heard by the same judge; both were urgent, one so much so that the hearing of the other was interrupted for the purpose.[55] The more urgent case, *Rochdale Healthcare NHS Trust v. C*,[56] received the most rudimentary of hearings. The proceedings have been graphically described by the lawyer for the hospital:

> At 4:30 pm a call was made to our Manchester office indicating that Mrs. C. was in labour in a trial of scar. Matters had not gone well and in the opinion of the Consultant, her uterus at the time was rupturing. He believed that he could deliver an intact baby within an hour, but if the matter were delayed further the child would die and shortly after so would the mother. The call was relayed to our London office and after taking direct instructions from the obstetrician we alerted the Official Solicitor who told us that another case raising similar issues was at that time in progress before Mr. Justice Johnson. We attended court and ascertained that the other case was slightly less urgent in the opinion of the attending consultants and the Court kindly broke off to take our case and made an Order some 35 minutes after the first contact with our Manchester office.[57]

The patient was not represented, and there was no *amicus curiae.* It is unclear from the transcript of the judgment whether the patient had any notice of the application. No formal evidence was before the court. The solicitor merely reported what he had been told by telephone from the hospital. This was to the effect that the patient objected to a Caesarean section because she had suffered backache and pain after a previous similar procedure. She said she would rather die than have a Caesarean section again.[58] There had been insufficient time to obtain a psychiatric opinion on the patient's competence, but the consultant obstetrician be-

55. *Rochdale Healthcare NHS Trust v. C* [1997] 1 FCR 274. For an account of what occurred, *see* Hempsons Lawyer 503 (3rd ed. 1996).

56. [1997] 1 FCR 274.

57. *Id.*

58. *Id.* For an account of what occurred, *see* Hempsons Lawyer 503 (3rd ed. 1996).

lieved her to be fully competent. In an understandably short judgment, the judge said he was acutely aware that the time for performing the operation had almost elapsed, and that he had only the scantiest information on which to act. However, he felt able to conclude that the patient lacked the mental competence to make the relevant decision:

> I accepted that view of the consultant obstetrician in relation to the first two elements in the analysis of Wall J in *Tameside* (supra) as to the capacity of the patient in the sense of her ability to comprehend and retain information and to believe such information. However I concluded that the patient was in the throes of labour with all that is involved in terms of pain and emotional stress. I concluded that a patient who could, in those circumstances, speak in terms which seemed to accept the inevitability of her own death, was not a patient who was able properly to weigh up the considerations that arose so as to make any valid decision, about anything of even the most trivial kind, surely still less one which involved her own life.[59]

Accordingly, he found it was in the patient's best interests to undergo the operation and made a declaration that such a procedure would be lawful. In his judgment, delivered some days later, the judge recorded that he had been informed that in fact by the time news of the declaration had been transmitted to the hospital, the patient had changed her mind and consented to the operation, which was performed successfully.

Despite the happy outcome, the judgment was the cause of some concern. Not only had an order been made on an *ex parte* basis, but the judge appeared to suggest in the passage quoted above that a woman "in the throes of labour" was incapable of making any decision, however trivial. Such a view is unlikely to appeal to labouring mothers or, indeed, women in general. Indeed, there appeared to be no evidence, of even an informal kind, to justify the finding. The judge seems to have been influenced by a perceived irrationality in refusing a Caesarean section to save a baby's life because of pain experienced. It seems that there may be a variety of views on whether such a decision is inevitably irrational, but, in any event, the general principle set out in *Sidaway v. Board of Governors of Royal Bethlem & Maudsley Hospitals*[60] precludes deciding competence on the basis of the absence of good reasons for a decision.

Another case, decided on the same day, *Norfolk and Norwich Health-*

59. *Id.*

60. [1985] AC 871 (HL).

care NHS Trust v. W,[61] was arguably only slightly less controversial. While the patient was not represented, the Official Solicitor provided leading counsel to act as *amicus*. However, there was no formal written or oral evidence and information was supplied to the court by counsel for the hospital and a representative of the Official Solicitor, both having spoken to the responsible consultants by telephone. It appeared that, although the woman was in the second stage of labour which had arrested, she denied she was pregnant. She had a history of psychiatric treatment. The consultant wished to effect delivery by forceps, but wanted authority to deliver by Caesarean section in the event that this failed. He considered that the fetus would die if it was not delivered within 1¼ hours of the time the application began. The attending consultant psychiatrist considered that, although the patient was not suffering from a mental disorder warranting detention under the Mental Health Act 1983, she was incapable of balancing treatment information given to her to make a choice. The judge could have found her incompetent on that ground alone, but he chose to go further:

> I held that although she was not suffering from a mental disorder within the meaning of the statute, she lacked the mental competence to make a decision about the treatment that was proposed because she was incapable of weighing up the considerations that were involved. *She was called upon to make that decision at a time of acute emotional stress and physical pain in the ordinary course of labour* made even more difficult for her because of her own particular mental history.[62]

He went on to find that the proposed method of delivery would be in her best interests to prevent damage to her uterus, and the detrimental psychological effects the death of the fetus would have on her. He also ruled that at common law reasonable force could be used as a necessary incident of treatment, thus deciding the point left open in *Tameside*, on the ground that it was in accordance with the doctrine of necessity enunciated in *Re F*.[63]

A hint at the reality of such decisions was given at the conclusion of the judgment:

> Throughout this judgment I have referred to 'the fetus' because I wish to emphasise that the focus of my judicial attention was upon the interests of the patient herself and not upon the inter-

61. [1996] 2 FLR 613.
62. *Id.* at 616 (emphasis supplied).
63. *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 (HL).

> ests of the fetus which she bore. However, the reality was that the fetus was a fully formed child, capable of normal life if only it could be delivered from the mother.[64]

Many would agree that a patient, who for reasons of mental disorder,[65] was incapable of believing she was pregnant in the circumstances of this case, should in some way be protected from danger. However, the judge in this case seems to have been influenced once again by a particular view of the abilities of labouring women, and by the dangers posed to a viable fetus. Furthermore, the court was prepared to make an order that effectively authorised compulsory invasive surgery and restraint at a hearing of which the patient appears to have had no notice, was unrepresented, and no presentation of any formal evidence occurred.

Barbara Hewson suggested:

> The assumption in the most recent cases seems to be that pregnant women are not really autonomous individuals entitled to equal protection, but merely a subdivision of what the courts once called infants and lunatics, incapable of making decisions for themselves, for whom doctors and courts should be surrogate decision-makers.[66]

B. Needle Phobias: Re L[67]

On December 5, 1996, the Family Division heard an application for a declaration in *Re L* that it would be lawful to insert needles for the purpose of anaesthesia, and to perform an emergency Caesarean section operation on a woman in labour. The hearing took twenty-four minutes and was attended by counsel for the hospital, and a representative of the Official Solicitor. Again there was no formal evidence before the court, only information relayed by counsel and the Official Solicitor who had obtained it from the consultant by telephone. The patient, in her twenties, was in labour at full term, but progress was obstructed. The consultant considered that without intervention, deterioration in fetal health and eventual death were inevitable. The patient wanted to have her child

64. *Id.* at 616.

65. Grubb, *supra* note 55, at 197. He states: "[I]t is difficult to believe that her denial of the obvious was based upon a difference of opinion or values rather than having a psychiatric history." It is clearly important for the court to be satisfied that the inability is due to mental disorder, rather than "the tendency most people have when undergoing medical treatment to self-assess and then puzzle over the divergence between medical and self-assessment." *See B v. Croydon Health Authority* (Thorpe J) [1994] 22 BMLR 13, 25.

66. Hewson, *supra* note 55, at 1386.

67. Family Division 5 December 1996 unreported: Kirkwood J.

safely, but suffered from an extreme needle phobia and would not consent to any injection such as would be necessary for an anaesthetic. The alternative to inducing anaesthesia by gas inhalation carried a sixty percent chance of causing the patient's death, and the anaesthetist considered this unacceptable.

It was reported that the consultant obstetrician considered the patient to be incapable of weighing treatment information to make a choice. The judge ruled that the patient lacked the capacity to make treatment decisions on the ground that:

> [H]er extreme needle phobia amounted to an involuntary compulsion that disabled L from weighing treatment information in the balance to make a choice. Indeed it was an affliction of a psychological nature that compelled L against medical advice with such force that her own life would be in serious peril.[68]

The judge was willing to make such a finding despite the absence of any psychiatric evidence or even reported opinion. However, where an urgent situation arises, it might be argued that it is better for the matter to receive some form of judicial review than for doctors to proceed without any external reference.

VII. A FINAL SOLUTION? *RE MB*[69]

The concerns raised by the previous cases were to some extent resolved in *Re MB*. The case concerned a woman who was thirty-three weeks pregnant with a footling breech presentation and an extreme needle phobia. If normal labour was allowed to proceed, there was a considerable risk of harm to the fetus, but little danger to the mother herself. She did not oppose a Caesarean section as such, but adamantly refused to allow any insertion of a needle for any purpose. In this case, the anaesthetist was prepared to take the risks involved in the gas inhalation technique, but the patient continually changed her mind as to whether she would consent to this.[70]

The case was heard in circumstances of considerable urgency: an appli-

68. *Id.* at transcript p. 3.

69. [1997] 38 BMLR 175; [1997] Fam Law 542; [1997] 2 FCR 541; [1997] 2 FLR 426.

70. Her consultant psychiatrist's opinion was as follows:

> Away from the need to undergo the procedure, I had no doubt at all that she fully understood the need for a caesarian section and consented to it. However in the final phase she got into a panic and said she could not go on. If she were calmed down I thought she would consent to the procedure. At the moment of panic, however, her fear dominated all.

Id. at transcript p. 6.

cation was made by telephone to a Family Division judge, Hollis J between 9:25 and 9:55 pm, when he granted a declaration according to the following terms:

> It shall be lawful for 2 days from the date of this order, notwithstanding the inability of [the patient] to consent thereto: (i) for the [hospital's] responsible doctors to carry out such treatment as may in their opinion be necessary for the purposes of the [patient's] present labour, including, if necessary, caesarian section, including the insertion of needles for the purposes of intravenous infusions and anaesthesia; (ii) for reasonable force to be used in the course of such treatment; (iii) generally to furnish such treatment and nursing care as may be appropriate to ensure that the [patient] suffers the least distress and retains the greatest dignity.[71]

The patient was represented by counsel who had some opportunity to take instructions from her, if only by telephone. The Official Solicitor's representative was present as *amicus*. No formal evidence was available, and as in previous cases, information gleaned by counsel for both parties was relayed by telephone to the judge.

Hollis J found that she lacked the mental capacity to make treatment decisions. An appeal was immediately launched against the decision, and a full Court of Appeal convened to hear it in open court at 11:00 pm The hearing concluded at 1:00 am the following morning with the dismissal of the appeal. As this was the first occasion on which a case of this type had been before the Court of Appeal, their reserved judgment addressed many of the problems seen above. The Court made several rulings that dealt with capacity, use of reasonable force, the interests of the fetus, and proper procedure.

It was emphasised that every adult is presumed to have the capacity to make decisions about treatment unless and until that presumption is rebutted, and that a competent person is entitled to make a decision:

> [F]or religious reasons, other reasons, for rational or irrational reasons or for no reason at all, choose not to have medical intervention, even though the consequences may be the death or serious handicap of the child she bears, or her own death. In that event the courts do not have the jurisdiction to declare medical intervention lawful and the question of her own best interests objectively considered does not arise.

The irrationality that the competent patient was entitled to indulge in was

71. *Id.* at transcript p. 7.

very wide ranging: "a decision so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it." However, the Court suggested that:

> Although it might be thought that irrationality sits uneasily with competence to decide, panic, indecisiveness and irrationality in themselves do not as such amount to incompetence, but they may be symptoms or evidence of incompetence. The graver the consequences of the decision, the commensurately greater the level of competence required to take the decision.

The Court approved of the *Re C* test described above, but added the gloss that temporary factors, such as confusion, shock, fatigue, pain, drugs, or panic induced by fear might destroy or erode capacity. It was emphasised that careful examination of the evidence was required to determine whether fear had destroyed capacity, as opposed to being a rational reason for refusal. Applying these principles to the facts, the Court held that the patient had lost her capacity by reason of her needle phobia dominating her thinking.[72]

The Court affirmed previous decisions on the reasonable use of force and held that reasonable force could be used where necessary to the best interests of the patient. The Court acknowledged that the issue may need to be examined in greater depth on a future occasion.

After a thorough consideration of statutes and case law, including human rights cases and American authorities,[73] it was emphatically held that there was no jurisdiction at common law to declare nonconsensual medical intervention to be lawful to protect the interests of the unborn child:

> The law is, in our judgment, clear that a competent woman who

72. By the time the Court of Appeal delivered their reserved judgment, affidavit evidence verifying the information given at the hearing had been filed.

73. *Re T (Adult: Consent to Medical Treatment)* [1993] Fam 95; *Paton v. British Pregnancy Advisory Service* [1979] QB 276; *C v. S* [1989] QB 135; *Burton v. Islington Health Authority* [1993] QB 204; *Attorney-General's Reference No 3* [1996] 1 Cr App R 351; *Villar v. Gilbey* [1907] AC 139; *Offences against the Person Act 1861* section 58; *Abortion Act 1967*; *Congenital Disabilities Act 1976*; *Bruggemann and Scheuten v. Federal Republic of Germany* [1977] 3 EHRR 244; *Paton v. United Kingdom* [1977] 3 EHRR 408; *H v. Norway* (1990) (Commission case no 17004/90, unreported); *Open Door and Dublin Well Woman v. Ireland* [1992] 15 EHRR 244; *Raleigh Fitkin-Paul Morgan Memorial Hospital Authority*, 201 A.2d 537 (N.J. 1964); *Jefferson v. Griffin Spalding County Hosp. Auth.* 274 S.E.2d 457 (Ga. 1981); *Crouse Irving Memorial Hospital v. Paddock*, 485 N.Y.S.2d 443 (N.Y. Sup. Ct. 1985); *In re AC*, 573 A.2d 1235 (D.C. 1990), 533 A.2d 611 (D.C. 1987); *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994).

> has the capacity to decide may, for religious reasons, other reasons, or nor no reasons at all, choose not to have medical intervention, even though . . . the consequence may be the death or serious handicap of the child she bears or her own death. She may refuse to consent to the anaesthesia injection in the full knowledge that her decision may significantly reduce the chance of her unborn child being born alive. The fetus up to the moment of birth does not have any separate interests capable of being taken into account when a court has to consider an application for a declaration in respect of a caesarian section operation.[74]

Thus, the court dealt a mortal blow to the validity of *Re S* as an authority and emphatically restored the primacy of the competent adult woman's autonomy, while seeking to maintain a level of protection for those who are incapable of making a decision for themselves.

Finally, the court offered procedural guidelines. While it was said that the court was unlikely to entertain an application for a declaration of this type unless capacity was in issue, it was suggested that "for the time being at least" doctors should seek a ruling on the issue of competence. It was unclear whether this related only to cases where there was a dispute on that issue. It was made clear that it was highly desirable for this type of case to be brought as soon as a potential problem was identified, rather than at the last desperate minute, and that the hearing should be *inter partes* with the mother being represented in all cases if she wished to be. It was also preferable for evidence on competence to be given by a psychiatrist.

A. Is the Law Now in a Satisfactory State?

Re MB has clarified the law in the most controversial area, namely the right of the competent woman to determine what is done with her own body, avowedly aligning the underlining principles in English law with those applied in the American courts.[75] It has provided further guidance on when obstetric treatment decision cases should be brought before the court, and has discouraged unjustified urgent applications made *ex parte* and without proper evidence.[76] However, there are a number of matters

74. [1997] 38 BMLR 175; [1997] Fam Law 542; [1997] 2 FCR 541; [1997] 2 FLR 426; transcript p. 28.

75. *See In re AC*, 573 A.2d at 1237; *In re Baby Boy Doe*, 632 N.E.2d. at 366.

76. This has undoubtedly had an effect. The writer has professional experience with one subsequent *ex parte* application in which the judge refused to make any ruling because there was no evidence of urgency requiring an immediate decision.

that remain unclear and where potentially serious threats to female autonomy lurk.

1. The Judicial Dilemma

It may be argued that the motivating factor in some of the more controversial decisions has been the understandable desire on the part of humane judges to err on the side of saving life when faced with an extreme urgency with no real opportunity to study complex case law or evidence in the face of an apparently irrational decision. This was clearly implied by Sir Stephen Brown P in his lecture referring to *Re S*:

> Now the academics have said that it was utterly wrong, it shouldn't have been done *ex parte* and it was a gross infringement of the rights of the mother. The consultant wrote me a letter afterwards . . . he said almost the same thing had happened with her second pregnancy, but somehow the Lord 'had provided' and that gave her the strength, as it were, and the purpose to go on in this occasion. But he made this remark at the end of the letter: 'It would have been very sad: she had two young children at home.' Well these are the human problems. There are legal problems. It would be splendid to have time to debate them in the calm of the Court of Appeal, if one had time, or even more in the House of Lords. But these are the problems which face doctors and which had faced us . . . . I am sure it is perhaps a good thing that the lady is able to continue looking after her children. That is the human aspect.[77]

Johnson J, in his judgment in the *Rochdale* case,[78] recorded that after the event he was informed that the patient had changed her mind and given her consent to the procedure; the operation had been successful, and both mother and baby were doing well. Understandably, he was reassured that he had differed from the psychiatrist on the question of competence. He concluded his judgment by saying "In the words of [the hospital's solicitor] 'this story may show that justice is more accessible than psychiatry.'"

Family Division judges typically exercise the wardship jurisdiction to protect children, even from themselves, but in this area they are expected to put aside their impression of right and wrong and allow apparently irrational decisions to lead to death. In such circumstances, and in the

77. *Matters of Life and Death*, *supra* note 30, at 61.
78. [1997] 1 FCR 274.

absence of any legislative guidance, it would not be surprising if they strained to find a means of avoiding such a consequence.

2. Capacity

Thorpe J's three-stage test of capacity, as elaborated in *Re MB*, is not without its problems. In particular, it allows a degree of uncertainty in relation to the effect of temporary conditions such as panic and pain, which may tempt a judge concerned to protect fetal life against an apparently irrational decision to err on the side of finding incompetence. Fear, pain, and panic are sensations experienced by many if not most hospital patients: are they to be in danger of being found incompetent because they express disagreement with their doctors, but perhaps are in too much pain to express their reasons clearly? If personal autonomy is the guiding principal, why should a perfectly normal human experience, untainted by mental disorder, render a person obliged to accept the decisions of others? If the wishes of an otherwise competent person in pain are to be ignored, should this not be discussed with him or her before that stage has been reached so that his wishes for the future are ascertained?

3. Procedure

It is suggested that the current procedure available to the English courts is profoundly unsatisfactory. A declaration that treatment proposed by the doctor is lawful is not a satisfactory substitute for a decision taken by or on behalf of the patient by a proxy decision maker, whether it is a guardian or the court. This is particularly so if a declaration must be granted when the doctor's opinion is consistent with a responsible and competent body of professional opinion, even if another such body of opinion holds a different view. The declaration that is then granted may depend on which body of opinion happens to have control of the care of the patient.[79]

4. A Solution?

One or both of two things should be done. First, a wardship or guardianship jurisdiction should be restored to the courts, so that judges can seek to protect fully the rights of those before it, as is done in many state jurisdictions in the United States. Second, Parliament should provide leg-

79. In fact, the English courts are probably prepared to decide between two reasonable proposals in this type of case. For example, *see Re S (Patient: Court's Jurisdiction)* [1995] 3 All ER 290.

islative guidance in connection with what, if any, recognition should be afforded to a fetus. This is a community issue that the judiciary is not inherently qualified to determine. Parliament has demonstrated repeatedly its ability and willingness to enter this arena,[80] and should do so again.

VIII. CONCLUSION

This series of cases demonstrates some of the strengths and weaknesses of judge-made law. Through a legislative omission, a jurisdiction to protect the mentally incompetent was removed, leaving no apparent means for court intervention in treatment decision making. The real danger of leaving such patients in a worse position than those able to make decisions for themselves was reduced by the introduction of the declaratory jurisdiction to enable a review of doctors' decisions to take place. It is strongly arguable that the legislature should introduce a more comprehensive system to enable proxy decision makers to be appointed, but in the absence of this, it might be thought that the present jurisdiction is better than nothing. Whether the House of Lords was correct to reject the opportunity to introduce transatlantic concepts of substituted judgment is a matter for debate. Of more concern has been the application by judges of values that do not necessarily attract universal support in a field where, at the very least, a variety of views is possible. An understandable desire to save life in circumstances where many might think it is being endangered unjustifiably by irrational decisions has arguably led to invasions of civil rights, the modification of which should only be the province of Parliament rather than the judiciary, in a jurisdiction where the courts are not as yet granted a role similar to the United States Supreme Court.

80. As with the ABORTION ACT 1967 and the HUMAN FERTILISATION AND EMBRYOLOGY ACT 1990.